NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 20, 2003

RE: MDR Tracking #: M2-03-1580-01-ss
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
The claimant has a history of chronic back pain and right leg pain allegedly due to a work injury of___. An MRI of the lumbar spine without contrast performed on 12/26/02 indicates disc space narrowing, disc desiccation, and diffuse posterior disc bulging at L3/4, L4/5 and L5/S1. The report documents stenosis at L3/4 and L4/5.

Requested Service(s)
Right lumbar laminectomy with scope at L3/4, L4/5 and L5/S1.

Decision
I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision
Generally a clinical work up of a neurocompressive lesion includes EMG/NCV studies to support a clinical diagnosis of radiculopathy and a myelogram prior to any consideration of surgical decompression. The neurologic exam and objective documentation by EMG/NCV study of a site specific radiculopathy must correlate with the anatomical findings on myelogram. There is no documentation of EMG/NCV studies supporting a diagnosis of lumbar radiculopathy or specifically identifying the pain generator site. There is no documentation of an anatomical defect on myelogram consistent with an isolated neurocompressive lesion that would necessitate decompression in this clinical setting.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

This decision by the IRO is deemed to be a TWCC decision and order.